

**WV DEPARTMENT OF HEALTH AND HUMAN RESOURCES
PROVIDER TAX IDENTIFICATION REPORTING FORM**

Organization/Individual Name: _____

Federal Employer Identification Number (FEIN) or Social Security Number: _____

Business Address: _____

Payment Address: _____

Telephone Number () _____ **Contact person:** _____

I wish to withdraw because:

I wish to continue providing services (If you mark this box, you must complete the remainder of the form)

Pursuant to Internal Revenue Service regulations, Providers must furnish their taxpayer identification number (TIN) to the State. If this number is not provided, you may be subject to a 20% withholding on each payment.

ENTER YOUR NAME AND ADDRESS EXACTLY AS YOU ENTER THEM ON YOUR IRS INCOME TAX FORMS

1099/Tax Name: _____

1099/Tax Address: _____

Federal Employer Identification Number (FEIN): _____ **or Social Security Number:** _____

List the Type of Service you are Approved/Licensed to provide:

TYPE	COUNTY (IF APPLICABLE)
_____	_____
_____	_____

Type of Business of Provider (Check One) Individual Sole Proprietorship Partnership
 Government/Non Profit Corporation Public Services Corporation Estate Trust

Other Tax Account Number(s) (if applicable): **State Sales Tax/Use Tax Number:** _____

State Unemployment Tax Number: _____ **State Corporation Income Tax Number:** _____

State Employers Withholding Tax Number: _____

Under penalties of perjury, I declare that I have examined this request and to the best of my knowledge and belief it is true, correct, and complete.

Name (Print): _____ **Signature:** _____

Date: _____ **Telephone: ()** _____ **Title:** _____